Defense Health Agency

PROCEDURES MANUAL

NUMBER 6025.01
December 20, 2019

DAD-MA

SUBJECT: Primary Care Behavioral Health (PCBH) Standards

References: See Enclosure 1.

1. PURPOSE. This Defense Health Agency-Procedures Manual (DHA-PM), based on the authority of References (a) and (b), and in accordance with the guidance of References (c) through (i), establishes the Defense Health Agency's (DHA) procedures to establish required standards for:

a. Military Medical Treatment Facilities (MTFs) and primary care clinics for adult, child and adolescent, health behavior, behavioral medicine, and behavioral health services in primary care.

b. Behavioral Health Consultants (BHCs).

c. Behavioral Health Care Facilitators (BHCFs).

d. External Behavioral Health Consultants (EBHCs).

e. Primary Care Clinic Leaders.

2. APPLICABILITY. This DHA-PM applies to DHA, Military Departments, DHA components (activities reporting to DHA, i.e., markets, MTFs); and all personnel to include: assigned or attached active duty and reserve members, federal civilians, contractors (when required by the terms of the applicable contract), and other personnel assigned temporary or permanent duties at DHA, to include DHA regional and field activities (remote locations), and subordinate organizations administered and managed by DHA.

3. POLICY IMPLEMENTATION. It is DHA's instruction, pursuant to Reference (e), that PCBH services are provided in primary care settings to improve patient access to behavioral health care, population health, readiness, physical and psychological health outcomes, and patient and provider satisfaction, while managing and decreasing health costs.

4. RESPONSIBILITIES. See Enclosure 2.

5. PROCEDURES. Detailed procedures for BHCs, BHCFs, EBHCs and primary care clinic leader on service delivery model, informed consent and disclosure, appointment types, assessment instruments, documentation, team feedback, excluded services, peer review and work schedule are detailed in Enclosures 3-6 of this DHA-PM.

6. RELEASABILITY. **Cleared for public release**. This DHA-PM is available on the Internet from the Health.mil site at: www.health.mil/DHAPublications.

7. EFFECTIVE DATE. This DHA-PM:

a. Is effective upon signature.

b. Will expire 10 years from the date of signature if it has not been reissued or cancelled before this date in accordance with Reference (c).

8. FORMS. The following forms are available from the sources listed below:

a. Alcohol Use Disorders Identification Test–Consumption (AUDIT-C): https://cde.drugabuse.gov/instrument/f229c68a-67ce-9a58-e040-bb89ad432be4

b. Behavioral Health Measure (BHM)-20: https://info.health.mil/hco/clinicsup/hsd/pcpcmh/bhi/Pages/Home.aspx

c. Brief Addiction Monitor (BAM): https://www.mentalhealth.va.gov/providers/sud/docs/BAM_Scoring_Clinical_Guidelines_01-04-2011.pdf

d. Columbia Suicide Severity Rating Scale (C-SSRS): https://info.health.mil/hco/clinicsup/hsd/pcpcmh/bhi/Pages/Home.aspx

e. CRAFFT-2.0: https://crafft.org/wp-content/uploads/2019/02/CRAFFT-2.0_Selfadministered_2018-01-16.pdf

f. Duke Health Profile (DUKE): https://fmch.duke.edu/sites/cfm.duke.edu/files/cfm/Research/HealthMeasures/DUKE%20Combined%20Form_revised%20Jan%202017.pdf

g. Edinburgh Postnatal Depression Scale (EPDS): https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/practicing-safety/Documents/Postnatal%20Depression%20Scale.pdf

h. Epworth Sleepiness Scale (ESS): https://www.cdc.gov/niosh/work-hour-training-for-nurses/02/epworth.pdf

i. Generalized Anxiety Disorder (GAD) Scale-2: https://integrationacademy.ahrq.gov/sites/default/files/GAD-2_0.pdf

j. GAD Scale-7 (GAD-7): https://www.integration.samhsa.gov/clinical-practice/gad708.19.08cartwright.pdf

k. Geriatric Depression Scale (GDS)-15: https://integrationacademy.ahrq.gov/sites/default/files/Update_Geriatric_Depression_Scale-15_0.pdf

l. Insomnia Severity Index (ISI): https://www.myhealth.va.gov/mhv-portal-web/insomnia-severity-index

m. Montreal Cognitive Assessment (MoCA): https://www.parkinsons.va.gov/resources/MOCA-Test-English.pdf

n. Mood Disorder Questionnaire (MDQ): https://www.integration.samhsa.gov/images/res/MDQ.pdf

o. National Institute for Children's Health Quality Vanderbilt Assessment Scales: https://www.nichq.org/sites/default/files/resource-file/NICHQ_Vanderbilt_Assessment_Scales.pdf

p. Patient Health Questionnaire (PHQ)-2: https://cde.drugabuse.gov/instrument/fc216f70-be8e-ac44-e040-bb89ad433387

q. PHQ-9: https://www.uspreventiveservicestaskforce.org/Home/GetFileByID/218

r. Pediatric Symptom Checklist (PSC)-17 and 35: https://www.massgeneral.org/psychiatry/services/treatmentprograms.aspx?id=2088

s. Primary Care-Posttraumatic Stress Disorder Screen (PC-PTSD): https://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp

t. Posttraumatic Stress Disorder (PTSD) Checklist for Diagnostic and Statistical Manual (DSM)-5 PTSD Checklist for Diagnostic and Statistical Manual of Mental Disorders (PCL)-5: https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp#obtain

u. The Saint Louis University Mental Status (SLUMS) Examination (): https://www.slu.edu/medicine/internal-medicine/geriatric-medicine/aging-successfully/assessment-tools/mental-status-exam.php

v. Wender-Utah Rating Scales (WURS): https://psycheducation.org/wp-content/uploads/2014/12/wender.pdf

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1. References
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Glossary

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REFERENCES

(a) DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," September 30, 2013, as amended
(b) DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013
(c) DHA-Procedural Instruction 5025.01, "Publication System," August 24, 2018
(d) DoD Instruction 6490.15, "Integration of Behavioral Health Personnel (BHP) Services into Patient-Centered Medical Home (PCMH) Primary Care and Other Primary Care Service Settings," August 8, 2013 as amended
(e) DHA-Procedural Instruction 6025.27, "Integration of Primary Care Behavioral Health (PCBH) Services Into Patient-Centered Medical Home (PCMH) and Other Primary Care Service Settings within the Military Health System," October 18, 2019
(f) Reiter, J. T., Dobmeyer, A. C. and Hunter, C. L, "The Primary Care Behavioral Health (PCBH) model: An overview and operational definition," Journal of Clinical Psychology in Medical Settings 2018[1]
(g) DHA-Interim Procedures Memorandum 18-001, "Standard Appointing Processes, Procedures, Hours of Operation, Productivity, Performance Measures and Appointment Types in Primary, Specialty, and Behavioral Health Care in Medical Treatment Facilities (MTF)," July 3, 2018
(h) DoD Manual 6025.18, "Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs," March 13, 2019
(i) DoD Instruction 6025.18, "Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule Compliance in DoD Health Care Programs," March 3, 2019

[1] This reference can be found at: https://doi.org/10.1007/s10880-017-9531-x

ENCLOSURE 2

RESPONSIBILITIES

1. DIRECTOR, DHA. Under the authority, direction, and control of the Under Secretary of Defense for Personnel and Readiness, Assistant Secretary of Defense for Health Affairs, and in accordance with References (a) through (i), the Director, DHA, will oversee compliance of this DHA-PM.

2. DHA PCBH PROGRAM DIRECTOR. The DHA PCBH Program Director must:

a. Work with the DHA PCBH Program Managers to ensure compliance with this DHA-PM.

b. Work with the DHA PCBH Committee, to ensure compliance with this DHA-PM and the collection, assessment and reporting of compliance to the Patient-Centered Medical Home-Advisory Board and future equivalent.

c. Work with DHA Market Leads, to ensure compliance with this DHA-PM.

d. Work with MTF staff to ensure compliance with this DHA-PM.

3. DHA PCBH PROGRAM MANAGERS. The DHA PCBH Program Managers must:

a. Provide oversight and management of MTF PCBH program training, implementation, sustainment, and evaluation to ensure compliance with this DHA-PM.

b. Work with DHA Market leads to ensure MTF PCBH services receive training, implementation support and are in compliance with this DHA-PM.

4. DHA PCBH COMMITTEE. DHA PCBH Committee must:

a. Meet no less than quarterly, commencing within 90 days following the issuance of this DHA-PM.

b. Evaluate and assist in execution of the requirements of this DHA-PM and provide technical guidance and assistance.

ENCLOSURE 3

BEHAVIORAL HEALTH CONSULTANTS SERVICE DELIVERY MODEL AND CLINICAL SERVICE STANDARDS

1. SERVICE DELIVERY MODEL

a. BHCs deliver services in a manner consistent with the evidence-based science for a PCBH model of service delivery as defined in the Glossary for adult, adolescent and pediatric patients in support of the overall health care goals of the Primary Care Manager (PCM) and the patient (see Appendix 1 for additional information).

b. BHCs function like PCM extenders for behavioral health, behavioral medicine and health behavior problems and must treat patients who are enrolled to a PCM in the clinic and appropriate for primary care services per standards in Reference (e) and this DHA-PM. Patients may be referred by PCMH team members, through self-referral, referral by the BHCF or referral from specialty clinics.

c. BHCs can initiate an initial individual or group appointment and see the patient for follow-up appointments without the PCM initiating a request for BHC assistance.

d. BHCs provide same-day verbal feedback to PCMs so the PCM is aware of the BHC assessment, intervention and recommendations on all initial and follow-up appointments unless the PCM requests an alternate method or frequency. If the PCM is not available for same-day verbal feedback the BHC shall use an alternate means to provide feedback. All protected health information encountered will be handled in accordance and compliance with References (h) and (i).

e. It is within the BHC's scope of practice to provide focused intervention and/or triage services to primary care team members (see Appendix 2 of this DHA-PM for additional details). Specifically, BHC services would only be available to primary care team members who are MTF beneficiaries and enrolled for medical care to the BHC's primary care clinic. Adherence to all relevant ethical guidelines and use of appropriate clinical judgment and caution is required to avoid over involvement in departmental conflicts or the significant personal problems of coworkers. When BHC services are provided, appropriate documentation in the electronic health record (EHR) and feedback to the PCM is required.

f. Warm handoff as defined in the Glossary, is the expected and preferred method by which patients move immediately from seeing their PCM to seeing a BHC. This provides convenient, one-stop/one-trip, same-day services for the patient and negates the possibility of a cancellation or no-show for a future initial BHC appointment.

g. A hallmark of the BHC position is availability to PCMs, thus BHC duty hours (HRs) should match those of the majority of PCMs in the clinic. Alternate work schedules (AWS) may be considered but are generally discouraged.

2. CLINICAL SERVICE STANDARDS INFORMED CONSENT AND BHC DISCLOSURE STATEMENTS. Initial Consultation:

a. A formal, signed, informed consent document is not required and shall not be given for BHC services. BHCs shall accomplish a verbal informed consent process by telling the patient:

(1) The BHC's name, role and profession as a behavioral health provider.

(2) The limits of BHC services.

(3) Reporting obligations and limits of confidentiality.

(4) Communication that must occur with their PCM regarding the content, findings, and recommendations that arise from BHC appointments.

(5) The encounter must be documented in the EHR.

b. An example introductory script can be accessed on the PCBH website: https://info.health.mil/hco/clinicsup/hsd/pcpcmh/bhi/Pages/Home.aspx.

c. The BHC shall document in the EHR that the patient was verbally provided with the information in Enclosure 3, paragraph 2a. (1)-(4).

d. The BHC shall ensure the patient is provided the required DHA standard BHC information sheet. The DHA information sheet is approved by the DHA PCBH Committee, is available on the PCBH website at: https://info.health.mil/hco/clinicsup/hsd/pcpcmh/bhi/Pages/Home.aspx, and may be altered only to include the clinic's address, phone number(s), and BHC's or other staff members' names. The BHC shall document in the EHR that this DHA information sheet was provided to the patient.

3. APPOINTMENT TYPES

a. BHCs shall use the primary care medical expense performance reporting system code approved by the DHA PCBH Committee for use in the legacy EHR and the approved equivalent in Military Health System (MHS) GENESIS.

b. Initial Consultations

(1) Are initiated through a 24HR or FTR appointment type not to exceed 30 minutes. Same day warm hand-offs are the preferred process for initial consultation (see Appendix 3 of this DHA-PM for additional information). Other appointment types may be used by BHCs for virtual or telephone visits as outlined in Reference (g), or its future equivalent.

(2) Appointment focus will typically include a functional biopsychosocial evaluation including description of symptoms; factors related to symptom onset, frequency, duration; aggravating and alleviating factors; evaluation for potential diagnostic clarification; treatment recommendations; and establishing operationalized behavior change goals.

(3) In some instances, may include identifying existing community resources (e.g., Military One Source, Military Family Life Consultant, Chaplain), or suggesting to the patient and the PCM that a referral to specialty care or TRICARE in-network provider may be indicated. However, unless medically contraindicated, the goal shall be to deliver and maintain care in the PCMH.

c. Follow-up Consultation

(1) Initiated through a 24HR or FTR appointment not to exceed 30 minutes. Other appointment types may be used by BHCs for virtual or telephone visits as outlined in Reference (g), or its future equivalent.

(2) Appointment typically focuses on supporting a behavior change plan or intervention based on earlier (initial) BHC consultation; occurs in tandem with a planned PCM visit or as standalone appointment. Can be same-day service or scheduled based on the patient's needs.

d. On-demand behavioral health consultation, BHC to PCM and PCMH Team Members.

(1) Unscheduled, PCM or team-initiated contact with the BHC only, does not include the patient, by phone or face-to-face.

(2) Generally, in response to an emergent situation requiring immediate or short-term response. Also, but not limited to team-based behavioral health interventions and care pathways.

e. Continuity consultation

(1) Assist patients requiring ongoing monitoring and follow-up for chronic health or behavioral health conditions, such as, but not limited to obesity, diabetes, chronic pain, or dysthymic disorder. Continuity consultation may also be appropriate for patients with high medical utilization.

(2) Continuity consultation visits focus primarily on monitoring progress, reinforcing behavior change plans, maintaining gains, and preventing relapse. Care is provided over longer periods of time than is typically the case with standard individual consultation appointments. For example, patients may be seen monthly or quarterly over several years to support management of a chronic condition.

(3) Continuity consultation typically occurs with less than 15 percent of the BHC's patients and should still remain consistent with a consultative (rather than specialty care) model. For example, patients with higher intensity symptoms who would benefit from a specialty intervention should be offered a referral. BHCs in clinics with higher enrollments of patients with chronic medical conditions should be expected to have a larger percentage of their appointments devoted to continuity consultation, whereas BHCs in clinics with healthier populations should provide fewer continuity consultation services.

(4) Patients seen for continuity consultation appointments should be booked into the standard BHC 24HR or FTR appointment slots.

f. Educational Classes. Focused, group-based intervention that replaces or supplements individual consultative intervention; promotes education and building skills. Generally, these are open classes with walk-in capability.

g. Shared Medical Appointments. Group appointments that address a specific behavioral aspect of treatments. May include, but are not limited to, chronic pain, diabetes, hyperlipidemia, insomnia or hypertension treatment adherence as well as procedures that require patient education such as pap smears and vasectomies.

h. Conjoint Consultation. An appointment with the BHC, PCM and patient to address an issue of concern to all.

4. ASSESSMENT INSTRUMENTS. PCBH model service delivery is not specialty behavioral health care, thus it is not appropriate to use specialty behavioral health clinical intake or outcome assessments. Primary care-appropriate symptom and functional change measures must be used (see Appendix 1 of this DHA-PM for additional details).

a. Required Measures

(1) The BHM-20 shall be given to every adult patient ($\geq$18 years-of-age) on every initial and follow-up appointment. This standard does not apply to educational classes or shared medical appointments.

(2) The Defense and Veterans Pain Rating Scale (DVPRS) shall be given to every adult patient on every individual appointment. For patients that BHCs are seeing for reasons other than pain, administer the first two pain intensity questions. If either of the pain intensity questions is four or higher, the supplemental questions will also be administered. Patients seeing the BHC for a pain-related appointment and scoring one or higher on pain in the last 24 hours or average pain in the last week questions, shall be given the DVPRS supplemental questions.

(3) The C-SSRS primary care version in the Armed Forces Health Longitudinal Technology (AHLTA) EHR and its MHS GENESIS equivalent shall be administered to every patient 12 years of age and older on every individual initial appointment for a given episode of care. Suicide risk shall be evaluated and documented for follow-up appointments but may be done via means other than the C-SSRS (e.g., patient response to BHM-20, PHQ-9 or other verbal assessment).

b. Optional Measures. As deemed clinically useful or indicated, the BHC can use measures in addition to the BHM-20 and DVPRS. Consideration should be made to the time and effort taken by the patient and BHC in completing and scoring additional measures. Consideration should also be made to include measures that would support team conversation with the PCM and shared-decision making. The data yielded should provide additional actionable information beyond the BHM-20 and DVPRS to justify use. Additional primary care appropriate measures include but are not limited to:

(1) Assessments of quality of life, health and behavioral health functioning; Duke Health Profile.

(2) Screening for anxiety; GAD-7 and GAD-2.

(3) Screening for children and adolescents; PSC-17 and PSC-35.

(4) Screening for drug and alcohol use in adolescents: CRAFFT-2.

(5) Screening for depression; PHQ-9, PHQ-2, GDS-15, Edinburgh Postnatal Depression Scale.

(6) Screening for mania symptoms; MDQ.

(7) Screening for alcohol use; The AUDIT-C.

(8) Substance use disorder screening; BAM.

(9) Screening for mild cognitive impairment; MoCA, The SLUMS Examination.

(10) Screening for Attention Deficit Hyperactivity Disorder; National Institute for Children's Health Quality Vanderbilt Assessment Scales, WURS.

(11) Screening for Posttraumatic Stress Disorder (PTSD); Primary Care-Posttraumatic Stress Disorder Screen, PTSD Checklist for DSM-5 and PCL-5.

(12) Screening for sleep disturbances; ESS and ISI.

5. DOCUMENTATION. Should be clear and concise so the PCM is well-informed of potential interventions for PCM follow-up contacts with the patient. A very brief clinical conceptualization, in most cases five sentences or less and the recommendations for the patient and PCM should be placed in the Assessment and Plan (A/P) section under the diagnosis in AHLTA so the PCM can easily access the information. Determination on where this information will be placed in MHS GENESIS will be made by the DHA PCBH Committee once the MHS GENESIS BHC documentation platform is complete.

a. All BHC patient encounters, face-to-face as well as virtual shall be documented in the EHR using the BHC Tri-Service Workflow Form documentation tabs in AHLTA and their MHS GENESIS equivalent.

b. Every BHC initial encounter must include documentation of:

(1) Referral problem/chief complaint.

(2) Verbal informed consent and BHC brochure provided.

(3) Whether feedback was provided to the PCM.

(4) Amount of time spent with patient, divided into time for assessment and time for intervention.

(5) Pain level using the DVPRS and supplemental questions when indicated per pain level rating.

(6) BHM-20 scores and interpretation.

(7) C-SSRS risk level.

c. BHC initial appointment desired documentation when applicable includes:

(1) Referring PCM.

(2) Alcohol use.

(3) Tobacco use.

(4) Caffeine use.

(5) If appointment is deployment related.

d. Screening. If other assessment measures are used (e.g., PHQ-9, GAD-7, AUDIT-C) total score is documented in the appropriate EHR location.

e. History of Present Illness (HPI)

(1) Type/nature of symptoms.

(2) Frequency of symptoms.

(3) Duration of problem.

(4) Factors making symptoms better.

(5) Factors making symptoms worse.

(6) Impact of problem on functioning in one or more major life domain (work, family, recreational activities, physical activities, spirituality).

(7) Psychoeducation and/or interventions match the presenting problem.

f. Mental Status Examination (MSE)

(1) Orientation to time, place and person.

(2) Affect.

(3) Mood.

(4) Suicidal ideation.

(5) Homicidal ideation.

g. Additional MSE items as outlined below should be included when appropriate per presenting problem, but are not required for every patient:

(1) Speech (e.g., rate, volume, articulation, coherence);

(2) Thought processes (e.g., rate of thoughts, content of thoughts, abstract reasoning);

(3) Associations (e.g., loose, tangential, circumstantial, intact);

(4) Abnormal or psychotic thoughts (e.g., hallucinations, delusions, preoccupation with violence, homicidal or suicidal ideation, obsessions);

(5) Judgment and insight;

(6) Memory (e.g., recent memory, remote memory);

(7) Attention span and concentration;

(8) Language (e.g., naming objects, repeating phrases); and,

(9) Fund of knowledge (e.g., awareness of current events, past history, vocabulary).

h. Review of Systems (ROS) as outlined below should be included when appropriate per presenting problem, but are not required for every patient:

(1) Change in appetite;

(2) Sleep disturbances;

(3) Fatigue; and

(4) Loss of pleasure.

i. A/P

(1) Diagnosis or diagnostic impression matches problem area and is supported by information in HPI, ROS, and MSE.

(a) Psychiatric: It is not necessary to use a DSM diagnosis. For most patient encounters, use of International Classification of Disease codes describing the symptom/condition being addressed in the encounter is appropriate (e.g., *Anticipatory guidance: Stress management*). BHCs should refer to the DHA PCBH Committee approved BHC Diagnostic and Coding Guidance document found on the PCBH website: https://info.health.mil/hco/clinicsup/hsd/pcpcmh/bhi/Pages/Home.aspx.

(b) Services related to a non-psychiatric condition may be coded but must have been initiated by a medical provider (e.g., migraine headaches or irritable bowel syndrome).

(2) Brief clinical impressions including a formulation that identifies one or more biopsychosocial factor related to onset or maintenance of the problem.

(3) Recommendations for patient.

(4) Recommendations for PCM.

j. Every BHC follow-up encounter must usually include documentation of:

(1) Administrative

(a) Referral problem/chief complaint.

(b) Whether feedback was provided to the PCM.

(c) Amount of time spent with patient, divided into time for assessment and time for intervention.

(d) Pain level using the DVPRS and supplemental questions when indicated per pain level rating.

(e) BHM-20 scores and interpretation.

(2) Screening: If other assessment measures used (e.g., C-SSRS, PHQ-9, GAD-7, AUDIT-C) total score is documented in the appropriate EHR location.

(3) Presenting Problem

(a) Changes in presenting problem/symptoms and functioning.

(b) Adherence and progress on previous recommendations.

(c) Psychoeducation and/or interventions matching the presenting problem.

(4) MSE

(a) Orientation to time, place and person.

(b) Affect.

(c) Mood.

(d) Suicidal ideation.

(e) Homicidal ideation.

(5) Additional MSE items as outlined below should be included when appropriate per presenting problem but are not required for every patient.

(a) Speech (e.g., rate, volume, articulation, coherence);

(b) Thought processes (e.g., rate of thoughts, content of thoughts, abstract reasoning);

(c) Associations (e.g., loose, tangential, circumstantial, intact);

(d) Abnormal or psychotic thoughts (e.g., hallucinations, delusions, preoccupation with violence, homicidal or suicidal ideation, obsessions);

(e) Judgment and insight;

(f) Memory (e.g., recent memory, remote memory);

(g) Attention span and concentration;

(h) Language (e.g., naming objects, repeating phrases); and,

(i) Fund of knowledge (e.g., awareness of current events, past history, vocabulary).

(6) ROS as outlined below should be included when appropriate per presenting problem but are not required for every patient.

(a) Change in appetite.

(b) Sleep disturbances.

(c) Fatigue.

(d) Loss of pleasure.

(7) A/P

(a) Diagnosis or diagnostic impression matches problem area and is supported by information in HPI, ROS, and MSE:

(b) Psychiatric: It is not necessary to use a DSM diagnosis. For most patient encounters, use of International Statistical Classifications of Diseases codes describing the symptom/condition being addressed in the encounter is appropriate (e.g., *Anticipatory guidance: Stress management*). BHCs should refer to the DHA PCBH Committee approved BHC Diagnostic and Coding Guidance document located on the PCBH website: https://info.health.mil/hco/clinicsup/hsd/pcpcmh/bhi/Pages/Home.aspx.

(c) Services related to a non-psychiatric condition may be coded but must have been initiated by a medical provider (e.g., migraine headaches or irritable bowel syndrome).

(d) Brief clinical impressions including a formulation that identifies one or more biopsychosocial factor related to onset or maintenance of the problem.

(e) Recommendations for patient.

(f) Recommendations for PCM.

k. Very brief consultations (e.g., 15 minutes or less),

(1) Documentation shall include:

(a) In the administrations section of the note, a statement that the appointment was brief with the approximate time of the appointment.

(b) Reason for referral.

(c) C-SSRS risk level.

(d) Homicidal ideation.

(2) Optional items:

(a) BHM-20 does not have to be administered. Rationale for not administering BHM-20 must be given.

(b) DVPRS does not need to be administered by the BHC if it was completed earlier in the day at a PCM appointment.

(c) When applicable, information on symptoms and functioning, intervention provided, and recommendations for patient and/or PCM.

l. Coding: One unit of a health and behavior code can be used if the appointment was a minimum of 8 minutes.

m. Documentation of sensitive issues: As a general rule, encounters should not be marked sensitive. Marking an encounter sensitive may interfere with the PCMH team (or any other medical team) viewing the documentation that is necessary to coordinate care and support the PCM's treatment plan.

n. PCM Feedback:

(1) Shall occur with every initial consultation appointment and adhere to the following:

(a) Be given within 24 hours after the patient contact.

(b) May be provided verbally or through method preferred by PCM (e.g., secure messaging, hardcopy note, phone call).

(c) Must be provided as soon as possible when patient is expressing suicidal or homicidal ideation.

(d) Generally provided in 3 minutes or less. PCMs may ask for additional information, if desired.

(e) Include the patient name, age, rank when applicable, and presenting problem. Factors related to initiating, maintaining and exacerbating symptoms and declined function. Intervention plan initiated, areas the PCM should ask about and address on PCM follow-up appointment.

(2) Shall occur with every follow-up consultation appointment and adhere to the following:

(a) Be given within 24 hours after the patient contact.

(b) May be provided verbally or through method preferred by PCM (e.g., secure messaging, hardcopy note, phone call).

(c) Must be provided as soon as possible when patient is expressing suicidal or homicidal ideation.

(d) Include the patient name, age, rank when applicable, presenting problem, significant clinical improvement or decline (based on objective scores on BHM-20 or other measure, or clinical judgment), and any elevated suicide or homicide risk level.

6. SCREENING, ASSESSMENT AND MANAGING PATIENTS WITH SUICIDAL IDEATION

a. Screening for suicidal ideation must occur for every patient at every individual initial appointment. The C-SSRS past month version in the AHLTA EHR and its MHS GENESIS equivalent must be administered to every patient 12 years of age and older. Suicide risk shall be evaluated and documented for follow-up appointments but may be done via means other than the C-SSRS (e.g., patient response to BHM-20, PHQ-9 or other verbal assessment).

b. When C-SSRS screening or other clinical information suggests elevated suicide risk, additional factors related to suicide risk should be assessed and documented. These factors include:

(1) Details of a past suicide attempt.

(2) Resolved plans and preparations to include specificity of plan, intensity of suicidal thoughts, preparation for suicide and rehearsal behaviors.

(3) Access to lethal means like the availability of firearms.

(4) Recent Psychosocial Stressors.

(5) Prior Psychiatric hospitalization.

(6) Psychiatric Conditions (e.g., mood disorders, substance use disorders or symptoms, hopelessness, insomnia, agitation).

c. Other applicable screening, evaluation items as detailed in the most recent Department of Veteran Affairs (VA)/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide.

d. Create a safety plan when required due to increased risk level:

(1) Create a safety plan based on level of risk. Safety plan should be a written, prioritized list of coping strategies and sources of support patients can use to alleviate a suicidal crisis.

(2) The safety plan should include the following steps: Recognizing warning signs of an impending suicidal crisis; employing internal coping strategies; using social contacts and social settings as a means of distraction from suicidal thoughts; using family members or friends to help resolve the crisis; contacting behavioral health professionals or agencies; restricting access to lethal means.

7. EXCLUDED SERVICES

a. Medical social work services (other than routine, community resource referrals).

b. Specialized case management services.

c. Psychotherapy, formal assessment/testing consistent with standards in a specialty behavioral health clinic, or diagnostic procedures exceeding focused assessment or focused intervention consistent with a PCBH model of service delivery.

d. Initiating, altering or stopping medications (including those credentialed and privileged to prescribe medications).

e. Group psychotherapy services (educational classes offered in the primary care clinic are appropriate).

f. Specialized occupational health, special duty evaluations, fitness for duty, and/or disability management services.

g. Initiation of a medical profile, or limited duty after the medical profile for active duty patients.

h. Assessment and recommendation for service/therapy animals.

i. Record review for PCBH related services prior to a permanent change of station or other security clearance type of reviews. While there may be a requirement for a records review for "mental health records" for services provided in a specialty mental health clinic services, PCBH services are not "specialty mental health" and there is no need for a records review since the EHR is already being reviewed by others.

j. Command-directed evaluations.

k. Forensic evaluations, sanity boards, and Medical Evaluation Boards.

l. Mandatory 7-day post-behavioral health hospitalization follow-up appointments. These follow-up appointments are to occur in specialty behavioral health clinics per Reference (g) and the future DHA-PI that will replace it.

8. PEER REVIEW

a. Conducted at least every 3 months, or in accordance with future DHA policy, and using the DHA PCBH Committee approved peer review form found on the PCBH website: https://info.health.mil/hco/clinicsup/hsd/pcpcmh/bhi/Pages/Home.aspx.

b. The frequency and number of records reviewed is mandated by local credentials offices or DHA guidance. However, at least 50 percent of records reviewed shall be initial encounters.

c. Completed either by a same profession (e.g., psychologist to psychologist), who works at the same MTF or another MTF in the Market as a BHC, or by a specialty behavioral health same-profession provider who uses the BHC peer review form for this function.

d. Results of peer review are reported to the BHC and credentials office.

e. For BHCs with >10 percent deficiencies on two consecutive peer review cycles, BHC raters must report results to the BHCs primary care clinical officer-in-charge to review documentation practices and discuss necessity for a performance improvement plan.

9. MISSED APPOINTMENTS. If a patient does not keep an initial or follow-up consultation appointment without canceling first, the BHC shall review patient information in the medical record to assess whether the patient may be at minimal or higher elevated risk of suicide based on C-SSRS if previously administered, or other documented clinical information consistent with elevated risk per VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide.

a. If risk indicators are not present, the BHC should document the "no show" in AHLTA using a telephone consultation note or in the MHS GENESIS equivalent. The documentation should include information regarding the review of recent medical information and the impression of level of risk for self-harm.

b. If the review of AHLTA or MHS GENESIS records reveals the patient may be at minimal or higher elevated risk of self-harm based on C-SSRS or VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide when a C-SSRS has not previously been administered, the BHC should attempt to reach the patient by phone to determine the reason for the missed appointment and to assess risk. This telephone contact should be documented when using the teleconsultation function or in the MHS GENESIS equivalent, and the PCM should be informed.

c. Appropriate steps to manage risk should be taken if the BHC judges that the patient is at elevated risk of suicide. If the patient is active duty and potentially at elevated risk for self-harm, but unable to be reached by phone, the BHC should notify the PCM and the patient's command.

10. ACTIVITIES TO INCREASE UTILIZATION. BHCs regularly engage in behaviors to increase BHC utilization using a diverse set of strategies, such as:

a. Foster positive relationships with all PCMH staff (PCMs, nurses, technicians, medical staff assistant).

b. Accept all referrals from PCMs and patient self-referrals. If the referral is truly inappropriate for PCBH, discuss with the PCM after the fact the reason why the referral was not appropriate.

c. Review the PCMs' patient schedules the night before to identify appropriate BHC referrals.

d. Attend huddles and discuss potential warm handoffs with the team by name and time of appointment. Follow-up with the PCMH team to establish a warm handoff process for those patients.

e. Train providers and staff how to conduct efficient warm handoffs, emphasizing how warm handoffs can benefit the PCM, the patient and the BHC.

f. Assist PCMs with managing severe/complex patients (not just low acuity patients).

g. Attend all provider meetings and ask for routine inclusion on the agenda.

h. Offer regular trainings to PCMs.

i. Initiate direct appointing for subsets of PCMH patients (e.g., sleep, depression, stress).

ENCLOSURE 4

BEHAVIORAL HEALTH CARE FACILITATORS DELIVERY MODEL AND CLINICAL SERVICE STANDARDS

1. SERVICE DELIVERY MODEL. BHCFs must monitor patients in a manner consistent with the evidenced-based science for a collaborative care model (CCM) of service delivery. A CCM is population-based model of care focused on a discrete clinical problem (e.g., depression or PTSD). It incorporates specific pathways using a variety of components that systematically and comprehensively address how behavioral health problems are managed in the primary care setting. PCMs and BHCFs share information regarding patients and there is a shared medical record, treatment plan, and standard of care. Typically, there is some form of systematic interface with a specialty care prescribing provider (e.g., weekly case review and treatment change recommendations).

2. BHCF SERVICE STANDARDS. BHCFs in addition to following standards as detailed in Reference (e) shall adhere to the following:

a. Work directly with patients who have been prescribed psychotropic medications for depression, anxiety, and/or PTSD by their PCM in a primary care clinic. These patients may be referred for BHCF services by the PCM, BHC, or other providers of the patient's primary care team. For example, if a PCM prescribes a patient a selective serotonin reuptake inhibitor for depression. A BHCF may follow up with the patient to see if they filled the prescription, took the medication, and if they are experiencing any side effects. The BHCF must use evidence-based procedures and administer a standardized behavioral health assessment tool as approved by the DHA PCBH Committee to measure symptom improvement and record the patient's adherence and response to treatment. This information is entered into the EHR, DHA PCBH Committee approved data tracking system, and the PCM is made aware of the patient's responses.

b. Assist the PCM in managing symptoms of depression, anxiety, and/or PTSD. Patients may participate in both BHC and BHCF services or either service individually. If the patient chooses to participate in both BHC and BHCF services, it is not a duplication of services. The BHCF must focus primarily on medication adherence, side effects, and monitoring symptom change over time, while the BHC must deliver brief interventions targeted at behaviors, thoughts, and emotions. For example, if a PCM prescribes a patient medication for depression, a BHCF may follow up with the patient to see if they filled the prescription, took the medication, is experiencing side effects or other barriers to adhering to the team's treatment plan. This team approach allows the patient to be closely monitored by both the BHC as well as the BHCF.

c. BHCF services follow a standardized assessment procedure whenever an encounter occurs with a patient. The program requires the use of a standardized screener appropriate to the conditions being followed (e.g., PHQ-9, GAD-7, or PCL-5) once every 4 weeks, or sooner (with a minimum 1-week interval between the same screening tool), at the discretion of the PCM or prescriber who will receive the results. PCMs and BHCFs share information through written notes in AHLTA and future MHS GENESIS equivalent and verbal dialogue in huddles, briefs, and debriefs (e.g., Team Strategies and Tools to Enhance Performance and Patient Safety or its future equivalent). In addition to written communication, there should also be some form of verbal communication between the BHCF and the PCM on patient status. All protected health information encountered will be handled in accordance and compliance with References (h) and (i).

d. Assist the BHC in managing workflow for BHC warm handoffs, assist with follow-up calls with patients that no-show for an appointment or cancel a BHC appointment. Scrub PCM appointment lists for patients that might benefit from a BHC appointment.

e. Assist the PCMH with managing the Antidepressant Medication Management Health Effectiveness Data and Information Set metric. BHCFs use Carepoint to identify PCMH patients currently on antidepressant medications (prescribed by a PCM) and contact non-compliant patients to enroll them in care facilitation services in consultation with the PCM. If the patient is prescribed medications by a provider outside of the PCMH, the BHCF must alert the appropriate point of contact (i.e., provider, case manager), of the patient's status, but will not enroll that patient into care facilitation services.

f. BHCFs do not engage in any form of specialty behavioral health care such as counseling or psychotherapy. The BHCF's prime focus is on behavioral health care facilitation for patients who are prescribed psychotropic medication for depression, anxiety, and/or PTSD by their PCM. However, the BHCF may be available to collaborate with patients presenting with a variety of behavioral concerns for whom the PCM is managing their medication. Tasks outside the care management model should be completed on a space available basis with the priority being maintaining a care management model caseload of 60-80 patients with depression, anxiety, and PTSD and providing care coordination for condition-based problems approved by the DHA PCBH Committee, such as a pain care coordinator in the stepped-care pain clinical pathway.

g. BHCFs may facilitate communication between the PCM and the specialty behavioral health provider to increase coordination of patient care. Although the BHCF is supporting the PCM treatment plan, the specialty provider must document any care recommendations in the medical record, the PCM is ultimately responsible for the health care plan of the patient.

3. BHCF EXCLUDED SERVICES. BHCFs shall not provide services:

a. For which they are not trained.

b. That is not part of their professional scope of practice based on training and licensure (see Appendix 2 of this DHA-PM for additional information).

c. That are prohibited by operating procedures under which they work.

d. Considered to be specialty behavioral health care, including counseling, psychotherapy or diagnostic procedures.

e. That are administrative duties for others in the primary care clinic, except the BHC.

f. That are specialized occupational health, special duty evaluations, and/or disability-management services.

g. That are medication management outside the BHCF's scope of practice.

h. That are suicide risk assessment and management. At the same time BHCFs can and should screen for suicide risk using the C-SSRS or other approved screening instrument.

i. That are medical triage.

j. Involving the role of a disease manager, Health Care Integrator, case manager, triage nurse, or PCM nurse.

4. INFORMED CONSENT AND BHCF DISCLOSURE STATEMENTS

a. A formal, written, informed consent document shall not be part of BHCF services. The informed consent "standard of care" for specialty behavioral health clinics does not apply to BHCF services provided in the primary care clinic.

b. The BHCF shall at initial patient contact:

(1) Inform the patient of the BHCF's name and role as a BHCF.

(2) Inform the patient of the limits of care that can be provided (i.e., the BHCF role is as a consultant only).

(3) Inform the patient that BHCFs have the same reporting obligations, particularly for active duty members, as any other medical provider.

(4) Inform the patient that BHCFs will communicate with his or her PCM and other treatment team members (e.g., BHC), regarding the content, findings and recommendations that arise from BCHF encounters.

(5) Give the patient the required standard BHCF information sheet (from the PCBH website: https://info.health.mil/hco/clinicsup/hsd/pcpcmh/bhi/Pages/Home.aspx) if the patient does not have it already and address any questions.

(6) Document in the EHR that this verbal informed consent was provided.

(7) A DHA PCBH Committee approved introductory script (from the PCBH website: https://info.health.mil/hco/clinicsup/hsd/pcpcmh/bhi/Pages/Home.aspx) must be used to ensure the nature of BHCF service is clear to all potential patients.

5. BHCF WORK SCHEDULE

a. Will be the same as the primary care clinic schedule in which they work. Typically, BHCFs keep the expected normal duty HRs (e.g., 0700-1600) schedule like most civilian and contracted employees, scheduling patient contacts during clinic HRs when PCMs or BHC are present in case assistance is required.

b. A hallmark of the PCBH program is to have PCBH personnel available to PCMs, thus BHCF duty HRs should match those of the majority of PCMs in the clinic. AWS may be considered but are generally discouraged.

6. ROUTINE CALL SCHEDULE

a. The routine schedule of calls is:

(1) Initial call: Week 1 (Range is 5 to 10 calendar days from the time patient is prescribed their medication by the PCM).

(a) Target is 5 to 10 calendar days from time of referral, baseline/diagnosis, or initiation of pharmacotherapy by the PCM.

(b) Explain role as BHCF and the program.

(c) Get baseline outcome measurement score (e.g., PHQ-9, GAD-7, PCL-5), if it was not previously collected by PCM team.

(d) Document encounter in Fast Informative Risk and Safety Tracker and Stepped Treatment Entry and Planning System (FIRST-STEPS) or future equivalent to include general concern, mandatory suicide and homicide risk screening, medication non-adherence, self- management, case status modules.

(e) Confirm patient's understanding of treatment plan and review current level of adherence. If patient is meeting treatment plan goals, schedule a follow-up call in 3 weeks (typically 4 weeks after the date of referral) and then every 4 weeks thereafter.

(f) If patient is not meeting treatment plan goals, problem-solve and assist in overcoming barriers. Document barriers and plan for patient activation and staff patient with BHC.

(g) Schedule follow-up call, agree on patient's action plan in interim, and close conversation. Include reminder that PCM and BHC (if following the patient also), will receive an update on patient progress.

(h) Consider referral to BHC for assistance with addressing barriers to treatment or to address other conditions (e.g., tobacco cessation, weight loss) that are not being monitored by BHCF.

(2) Routine calls must occur 4 weeks from the time the PCM prescribed the medication/referral.

(3) Continue 4-week interval contacts until remission or case closure (as determined through consultation with PCM).

b. Subsequent routine calls:

(1) Occur every 4 weeks from date of diagnosis/referral.

(2) Review all case information prior to call via FIRST-STEPS or future equivalent, PCM and BHC notes, and other related notes in the EHR.

(3) Document all attempts to contact patient in FIRST-STEPS or future equivalent and transfer note to EHR.

(4) Verify and update any change in physical address, contact numbers, or other changes.

(5) Review treatment adherence, discuss barriers.

(6) Obtain new PHQ-9, GAD-7, and/or PCL scores and provide basic feedback to patient and PCM on change in scores.

(7) If improving on target (e.g., 5 or more-point drop in severity), review any updates needed to self-management plan and book next contact.

(8) If not improving on target, use Motivational Interviewing to discuss barriers, any changes impacting health, consider as needed call and/or visit to BHC and/or PCM.

(9) Staff case with BHC or EBHC if not improving.

(10) Summarize patient contact and staffing recommendations in EHR and verbally follow-up when possible with PCM.

(11) If patient does not return calls/messages: document four instances of contact attempts over the course of 4 weeks (1 attempt per week), in the EHR then discuss disenrollment with PCM.

c. Calls as needed:

(1) Are made outside the "routine" schedule.

(2) May be initiated by patient or the BHCF.

(3) Are made any time the BHCF determines it necessary to facilitate the patient's adherence to treatment.

(4) May be initiated based on BHC staffing and/or PCM recommendations.

(5) Are to be documented in FIRST-STEPS or future equivalent and the EHR but may not require a teleconsultation to PCM.

(6) May involve an additional screening (outside the routine time period of every 4 weeks), using the PHQ-9, GAD-7, or PCL-5 at the discretion of the BHCF. Screeners must have a 1-week lapse between each use.

7. CONTACT AND COMMUNICATION PROTOCOL

a. Engage the patient:

(1) Verify patient identity by asking for full name and date of birth.

(2) Ask about privacy first.

(3) Ask how much time they have to talk.

(4) Remind patient that information from the call will be conveyed to PCM and/or BHC.

b. General information gathering:

(1) Identify self and connection to the PCM using introductory script.

(2) Stay within the BHCF's role to guide, not provide therapy.

(3) Answer questions about BHCF and depression, anxiety, and/or PTSD.

(4) Establish method and routine for calls.

(5) Explain method of communication with PCM and/or BHC.

(6) Inquire how patient is doing.

(7) Determine whether patient is currently engaged with primary care.

(8) Focus on whether anything has changed clinically or administratively.

(9) Follow established structured interview from FIRST-STEPS or equivalent to gather information about patient's current status with regard to symptoms and treatment adherence.

8. PEER REVIEW

a. Shall be conducted at least every 3 months, or in accordance with future DHA policy, and using the DHA PCBH Committee approved peer review form.

b. The frequency and number of records reviewed is mandated by local credentials offices or DHA policy. However, at least 50 percent of records reviewed shall be initial encounters.

c. Shall be completed either by a same profession (e.g., nurse to nurse), who works at the same MTF, or a another MTF in the Market as a BHCF, a BHC or a specialty behavioral health provider who uses the BHCF peer review form for this function.

d. Results of peer review are reported to the BHCF.

e. For BHCFs with >10 percent deficiencies on 2 consecutive peer review cycles, BHCF raters must also report peer review results to the BHCF's primary care clinical officer-in-charge to review documentation practices and discuss necessity for a performance improvement plan.

ENCLOSURE 5

EXTERNAL BEHAVIORAL HEALTH CONSULTANTS CLINICAL SERVICE STANDARDS

1. SERVICE DELIVERY MODEL. The EBHC is a specialty behavioral health asset with prescription privileges, typically a psychiatrist (though the role may be filled by a psychiatric nurse practitioner, specially trained physician assistant, or a prescribing psychologist). The EBHC is not within the PCMH but works in an outpatient BH clinic and their primary responsibility is to enhance the PCM's management of psychoactive medications by providing verbal and written consultation on initial medication decisions, changing or discontinuing medications, and managing side effects. The EBHC must advise the PCM regarding work-ups of neuro-psychiatric symptoms (e.g., need for neuro-imaging, laboratory testing, electroencephalogram, etc.), ongoing management of psychotropic medications (e.g., drug-level monitoring, chemistry/CBC/urine testing, etc.), and recommendation for referral to specialty BH care. Upon request, the EBHC must also consult with the BHC regarding behavioral health cases.

2. EBHC SERVICE STANDARDS

a. EBHC must meet telephonically or in person with BHCF(s) to review patients on BHCF caseload. Meetings must be at least every 14 days, and sooner as clinically indicated to review progress of patients in caseload.

b. EBHC must document review of cases (to include risk factors, barriers to care, treatment non-responders, deployment related issues, medication side effects, suicide risk etc.), as well as any treatment recommendations, in the EHR. EBHCs must not solely rely on BHCF to verbally pass on information to the PCM. All protected health information encountered will be handled in accordance and compliance with Reference (h) and (i).

c. EBHC must be available to consult with BHC on an as needed basis.

d. EBHC must be available for pharmacological consultation with PCMs on an as needed basis via telephone or secure messaging.

e. EBHCs must provide in-service trainings to PCMs on psychotropic medication management if requested by primary care leadership and approved by BH leadership.

3. EBHC EXCLUDED SERVICES

a. EBHC must not initiate, alter or stop prescriptions for primary care patients, but may make recommendations for PCM to initiate or change medications for a certain condition.

b. EBHC must not order procedures for primary care patients (e.g., laboratory work, imaging), but may make recommendations for PCM to initiate procedures for patient management.

c. EBHC must not have any direct clinical contact with primary care patients (to include assessment, individual or group therapy, specialty evaluations, etc.). Note: The EBHC is not prohibited from seeing the patient in a different context or role. Although while in the EBHC role they would not have direct clinical contact, they might have direct patient contact in another role (e.g., if patient is referred to specialty behavioral health).

ENCLOSURE 6

PRIMARY CARE CLINICAL LEADER

PCMH LEVEL MANAGEMENT. The primary care clinic officer-in-charge (or civilian equivalent) must:

a. Have responsibility for ensuring that implementation, training, and sustainment standards for PCBH services in this DHA-PM are met at the primary care clinic level (see Appendices 4 and 5 of this DHA-PM for BHC phases of training and competency evaluation).

b. Address no show rates equal to or greater than 33 percent on 2 consecutive months and compare the BHCs no-show rate with that of the clinic PCM average, which can be important contextual information.

c. May consider implementing reminder calls to patients (automatic, BHCF or other process). Additionally, emphasize strategies to increase the use of same day warm handoffs of patients from the PCM to the BHC.

d. Ensure their clinic has a Standard Operating Procedure for management of patients with elevated suicidal risk.

e. Emphasize strategies to increase enrollment in BHCF services of patients placed on psychotropic medications.

f. Should actively consult and seek support from DHA PCBH program managers in meeting the standards in this DHA-PM.

APPENDIX 1

PRIMARY CARE BEHAVIORAL HEALTH RATIONALE

POPULATION HEALTH AND THE PCBH MODEL

a. Population health management can be broadly defined as a systematic and integrated approach to improving the health of a given population by changing the policies and systems that impact health care access, quality, and outcomes.

b. Population health includes interventions and clinical applications focused on the entire patient population, not individual patients. Less intensive interventions, delivered to all beneficiaries who might benefit, have the potential for greater impact on the overall population than more intensive treatment for a smaller number of patients.

c. Clinical care may account for only 20 percent of the variance in health outcomes, with another 30% accounted for by modifiable health behaviors, which are potential targets for primary care intervention. The BHC could be the primary intervention provider, offering services individually or in a group format and when appropriate leveraging the assistance of other team members to reinforce, introduce and follow-up on patient health care management/improvement plans.

d. The goal of the PCBH service is to integrate the BHC in the primary care delivery system. BHCs act as PCM extenders, bringing specialized knowledge to bear on problems the PCM thinks require additional support, and assisting with implementation and monitoring of treatment plans. The BHC may see the patient for focused assessment and skill building for as long as the PCMs and the BHC deem necessary in order for good collaborative care to occur.

e. Behaviorally based interventions have demonstrated clinical effectiveness with a wide range of behavioral health disorders and psychosocial problems including depression, panic disorder, GAD, and chronic pain. Research has demonstrated these approaches can be tailored to fit in primary care without loss of clinical effectiveness.

f. The PCBH model addresses behaviors that affect physical health, not just emotional health. Behavioral interventions are effective for promoting health behaviors (e.g., breast cancer screening, exercise), reducing high risk behaviors (e.g., smoking cessation), and reducing morbidity and mortality among patients with chronic and/or progressive diseases (e.g., myocardial infarction).

g. Behavioral health interventions are easily implemented by the patient using self-care models already widely employed in the PCMH management of chronic diseases such as diabetes. These models focus on teaching the patient self-management and behavior change skills and place more responsibility on the patient.

h. The PCBH model allows both the truly "sick", that is individuals with acute or ongoing chronic health conditions, to continue to receive intensive treatment while providing those in the "healthy" population, that is those who might be at risk for developing health problems, as well as those with sub-clinical, pre-morbid symptoms, an opportunity for care as well. Providing care to this "healthy" population may result in delaying the onset or possibly halting a disease process.

i. Studies in the civilian sector have shown that integrating behavioral health services into primary care can improve patient satisfaction, improve medical provider satisfaction, decrease patient symptoms, increase functioning, and reduce health care costs.

APPENDIX 2

PRIMARY CARE BEHAVIORAL HEALTH HIRING GUIDANCE

1. BHC HIRING

a. It is recommended that BHC hires be clinical or counseling licensed psychologists who have received doctoral degrees from American Psychological Association approved programs and an American Psychological Association approved pre-doctoral internship. Training and state-level licensure must allow them to function as independent health care providers. Licensed clinical social workers may also be hired as BHCs. Training and state-level licensure must allow them to function as independent health care providers.

b. BHCs should have knowledge of evidence-based treatments for behavioral health and behavioral medicine conditions.

c. BHCs should have experience implementing cognitive and behavioral-based treatment interventions for a variety of presenting problems.

d. BHC should have experience and comfort interacting with medical and other primary care-based professionals.

e. Ideal BHC candidates would also have the following:

(1) Experience with the PCBH model of behavioral health care integration into primary care environments to include 30-minute appointments and a focus on functional impact and symptom reduction.

(2) Familiarity with population health principles and able to articulate differences in treatment between population-based health care and specialty services.

(3) Typing and basic computer proficiency with the ability to enter patient information into electronic medical record during patient encounters.

(4) Motivational interviewing skills.

(5) Experience working with active duty personnel, and/or experience working in MTFs.

(6) The characteristics of an ideal BHC: Team player; proactive and entrepreneurial; flexible/adaptable; approachable.

(7) Training in health psychology principles.

2. BHCF HIRING

a. BHCFs must be registered nurses with at least 3 years of experience in an ambulatory or inpatient setting.

b. BHCFs must have experience working with patients experiencing behavioral health symptoms, and a working knowledge of common behavioral health conditions.

c. BHCFs must have knowledge of evidence-based treatments, including pharmacological treatments, for a variety of medical and behavioral health conditions that present in primary care settings.

d. BHCFs must be comfortable consulting with primary care and physicians and providers from other specialties.

e. Ideal BHCF candidates must also have the following:

(1) Experience using validated tools to monitor depression, anxiety and PTSD symptoms and severity (PHQ-9, GAD-7 and PCL).

(2) Experience working with active duty personnel, and/or experience working in MTFs.

APPENDIX 3

BEHAVIORAL HEALTH CONSULTANTS TEMPLATE MANAGEMENT

BHC templates must consist of a minimum of 60 appointments per week. A utilization goal for all BHCs is a minimum of 40 completed encounters per week. Virtual and Group appointments should be taken into account for the 40 encounter goal. A 60-minute group encounter with at least two participants shall count as two encounters and group encounters must have at least two participants.

a. BHCs having AWS must also have at a minimum 60 individual appointments per week; BHC appointment availability must overlap with available PCM appointments.

b. BHC daily appointments must consist of a combination of FTR appointments and 24HR appointments to ensure same day availability for PCM warm hand-offs. 24HR appointments must be available in the morning and afternoon. Ideally, the 24HR appointments should be spaced in the schedule every 60 to 90 minutes so patients with same-day needs do not have an excessive wait time to see the BHC.

c. Any FTR appointments not scheduled by the end of the prior day must be converted to 24HR appointments.

d. BHC templates must be reviewed regularly (at least twice annually; January and July), to evaluate the use of 24HR vs FTR appointments.

(1) If more than 25 percent of available 24HR appointments are not being used, the BHC must initiate a performance improvement project to increase same day warm hand-offs.

(2) If more than 25 percent of available 24HR appointments are not being used, the ratio of 24HR to FTR appointments must be modified to increase FTR appointments.

e. The following is an example BHC template. In this example the 0930, 1130 and 1430 unscheduled times when not seeing a patient could also be used for activities such as communication with PCMs and other team members and EHR documentation:

TABLE: BHC SAMPLE SCHEDULE

Morning	*Afternoon*
0800 FTR	1300 24HR
0830 FTR	1330 FTR
0900 24HR	1400 FTR
0930 open for a warm handoff/walk-in	1430 open for a warm handoff/walk-in
1000 FTR	1500 24HR
1030 24HR	1530 FTR
1100 FTR	1600 24HR
1130 open for a warm handoff/walk-in	

7 FTR appointments
5 24HR appointments
= 12 BHC appointments/day

APPENDIX 4

BEHAVIORAL HEALTH CONSULTANTS PHASES OF TRAINING

1. ORIENTATION AND SELF-GUIDED PREPARATORY TRAINING. A distance learning program that occurs after the hiring process is completed. Required learning activities for this phase of training consist of webinar attendance, readings, and meetings with clinic personnel; activities are detailed in an orientation training document. Completion of tasks is verified by the BHC supervisor and is a pre-requisite to attending Phase I training. BHCs must not provide patient care in the PCMH during this period.

2. PHASE I: DEMONSTRATION OF BASIC BHC COMPETENCIES. In-person, DHA training course, currently held at Walter Reed National Military Medical Center in Bethesda, Maryland. BHCs must not provide patient care in the PCMH prior to completion of this phase of training. Successful completion of Phase I involves demonstrating Phase I competencies from the DHA BHC Core Competency Tool and is a necessity for being able to see patients upon return to their clinic. Inability to demonstrate competencies in Phase I may result in appropriate administrative personnel action.

3. PHASE II: ONGOING CONSULTATION. The BHC must participate in ongoing consultation with the PCBH Program Manager. This Phase is typically 3-6 months depending on the rate of skill acquisition by the BHC. The BHC must be involved with mentorship calls with a DHA expert trainer during this phase. Successful completion of Phase II is accomplished by having a DHA expert trainer on site and the BHC demonstrating Phase II competencies from the DHA BHC Core Competency Tool. Final verification of meeting the required core competencies shall be confirmed by a DoD PCBH Program Manager. Inability to demonstrate these competencies may result in appropriate administrative personnel action.

APPENDIX 5

BEHAVIORAL HEALTH CONSULTANTS COMPETENCY EVALUATION AND EXPERT TRAINER RECOGNITION

1. STANDARD PRACTICE. Is the desired end stage of evaluation where BHCs can function as consultants in the MHS but continue to participate in trainings and program evaluation activities. To ensure quality of care delivered by BHCs, periodic competency re-evaluations may occur. Failure to pass a re-evaluation may result in an appropriate administrative personnel action.

2. ACCREDITATION AS AN EXPERT TRAINER. This level of training is reserved for highly skilled BHCs who have an interest and aptitude for becoming Expert BHC Trainers. Certification as a BHC Expert Trainer must be coordinated by the PCBH Program Director and requires demonstration of competencies on the BHC Trainer Core Competency Tool. BHC Expert Trainer responsibilities may include assisting with Orientation, Phases I and II trainings, as well as other training or program evaluation activities as requested.

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

A/P	Assessment and Plan
AUDIT-C	Alcohol Use Disorders Identification Test–Consumption
AWS	alternate work schedule
BAM	Brief Addiction Monitor
BHC	Behavioral Health Consultant
BHCF	Behavioral Health Care Facilitator
BHM	Behavioral Health Measure
CCM	collaborative care model
DSM	Diagnostic and Statistical Manual
DUKE	Duke Health Profile
DVPRS	Defense and Veterans Pain Rating Scale
EPDS	Edinburgh Postnatal Depression Scale
ESS	Epworth Sleepiness Scale
GAD-2	Generalized Anxiety Disorder 2-item Scale
GAD-7	Generalized Anxiety Disorder 7-item Scale
GDS-15	Geriatric Depression Scale-15
EHR	electronic health record
FTR	future
FIRST-STEPS	Fast Informative Risk and Safety Tracker and Stepped Treatment Entry and Planning System
HPI	history of present illness
HR	hour
ISI	Insomnia Severity Index
MDQ	Mood Disorder Questionnaire
MoCA	Montreal Cognitive Assessment
MSE	Mental Status Examination
MTF	Military Medical Treatment Facility
PCBH	Primary Care Behavioral Health
PCL-5	Posttraumatic Stress Disorder Checklist for Diagnostic and Statistical Manual of Mental Disorders-Fifth edition

PCM	Primary Care Manager
PCMH	Patient-Centered Medical Home
PC-PTSD	Primary Care-Posttraumatic Stress Disorder Screen
PHQ	Patient Health Questionnaire
PSC	Pediatric Symptom Checklist
PTSD	Posttraumatic Stress Disorder
ROS	Review of Systems
SLUMS	Saint Louis University Mental Status
VA	Department of Veteran Affairs
WURS	Wender-Utah Rating Scales

PART II. DEFINITIONS

These terms and their definitions are for the purposes of this DHA-PM.

5As. Assess, Advise, Assist, Agree and Arrange, is an evidence-based behavioral intervention strategy that helps increase patient motivation and behavioral change. It also serves to structure initial BHC visits to maximize the efficiency and effectiveness of the encounter.
Each phase should be completed prior to transitioning to the next Phase with minimal to no back and forth between phases.

Assess. Obtain information on the referral question/presenting problem and conduct biopsychosocial and functional assessments to gather relevant information and begin to frame potential interventions (approximately 10-15 minutes).

Advise. A brief biopsychosocial formulation with the patient. This formulation is not a simple summary, rather a case formulation that helps the patient understand the origin of their symptoms and biopsychosocial factors maintaining the problem. The second half of the Advise phase the patient either identifies on their own or is presented with one to three evidence-based interventions that will address the patient's symptoms, along with a brief rationale of why each intervention would be effective (approximately 2-4 minutes).

Assist. Provide an intervention appropriate for the primary care setting. The intervention should be evidence-based, supportable by PCMH team, and have a self-management and home-based focus. The intervention should be taught/modeled/practiced during the appointment and a written plan for home practice (in Specific, Measurable, Achievable, Relevant, and Time-bound (SMART) format) should be provided to the patient (Approximately 5-10 minutes).

Agree. Collaboratively reach agreement with the patient on the plan of care (which intervention the patient would like to pursue (approximately 1-2 minutes).

Arrange. Develop plan for continued care (e.g., follow-up with BHC, follow-up with PCM,

specialty referral, no follow-up necessary and return as needed).

CCM. A population-based model of care focused on a discrete clinical problem (e.g., depression). It incorporates specific pathways using a variety of components that systematically plus, comprehensively address how behavioral health problems are managed in the primary care setting. PCMs and BHCFs share information regarding patients and there is a shared medical record, treatment plan, and standard of care. Typically, there is some form of systematic interface with specialty care (e.g. weekly case review and treatment change recommendations).

Continuity Consultation. Assist patients requiring ongoing monitoring and follow-up for chronic conditions, such as but not limited to obesity, diabetes, or chronic pain. Continuity consultation typically should occur with less than 15 percent of the BHC's patients, and should still remain consistent with a consultative (rather than specialty care) model. For example, the patient may be seen quarterly by the BHC (rather than monthly).

Direct Appointing. Patient booked to an appointment through patient self-initiated call to booking entity, requesting an appointment for a given problem. Based on booking protocols patient is booked directly with the team member (e.g., BHC, Clinical Pharmacist, Physical Therapist), who is likely the best suited to address their problem presentation.

Episode of Care. Services provided to a patient for a specific problem within a specific period of time. Clinical judgment should be used to determine when an episode of care has ended and a new episode begins. For example, a patient seen for five appointments for chronic pain, over eleven weeks with the fifth appointment being the last has completed an episode of care for that problem presentation. If that patient returns for an appointment in the future for help with pain, the BHC should consider time since last appointment, severity, presentation or other factors when making a determination on the appointment being a new episode of care or a continuation of the previous episode. The same patient returning for an appointment with a different problem (e.g., depression, marital problems) would be considered a new episode of care.

PCBH Model. A team-based primary care approach to managing behavioral health problems and biopsychosocially influenced health conditions. The model's main goal is to enhance the primary care team's ability to manage and treat such problems/conditions, with resulting increased access and improvements in primary care services for the entire clinic population. The model incorporates into the primary care team a BHC to extend and support the primary care team. The BHC works as a generalist and an educator who provides high volume services that are accessible, team-based, and a routine part of primary care. Specifically, the BHC assists in the care of patients of any age and with any health condition (Generalist); strives to intervene with all patients on the day they are referred (Accessible); shares clinic space and resources and assists the team in various ways (Team-based); engages with a large percentage of the clinic population (High volume); helps improve the team's biopsychosocial assessment and intervention skills and processes (Educator); and is a routine part of biopsychosocial care (Routine). To accomplish these goals, BHCs use focused (15-30 min) visits to assist with specific symptoms or functional improvement. Follow-up is based in a consultant approach in which patients are followed by the BHC and PCM until functioning or symptoms begin improving; at that point, the PCM resumes sole oversight of care but re-engages the BHC at any

time, as needed. Patients not improving are referred to a higher intensity of care, though if that is not possible, the BHC may continue to assist until improvements are noted. This consultant approach also aims to improve the PCM's biopsychosocial management of health conditions in general (Reference (f)).

Psychotherapy. Also called "talk therapy" or just plain therapy is a process whereby psychological problems are treated through communication and relationship factors between an individual and a trained behavioral health professional. Modern psychotherapy is time-limited, focused, and usually occurs once a week for 45-50 minutes per session.

Scrub. Reviewing PCM patient appointment lists prior to clinic (e.g., the day before or prior to morning and afternoon PCM clinic), to proactively identify patients that might benefit from a BHC appointment.

Warm Handoff. In this strategy, a warm handoff is a handoff that is conducted in person, between two members of the health care team, in front of the patient (and family if present). It includes the patient as a team member so that he or she can hear what is being discussed about the clinical problem, current status, and plan of care. Warm handoffs are the preferred method for transferring patients to BHC care as they negate the potential for cancellations and no-shows in contrast to appointments scheduled in the future.